

Proposal Cover Page

Name of Bidding Firm *(Legal name as it will appear on the contract)*

Mailing Address *(Street address, P.O. Box, City, State, Zip Code)*

Person authorized to act as the contact for this firm in matters regarding this proposal:Printed Name *(First, Last)*:

Title:

Telephone number:

Fax number:

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Person authorized to obligate this firm in matters regarding this proposal or the resulting contract:Printed Name *(First, Last)*:

Title:

Telephone number:

Fax number:

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(CORPORATIONS) Name/Title of person authorized by the Board of Directors to sign this bid on behalf of the Board:Printed Name *(First, Last)*:

Title:

Signature of Bidder or Authorized Representative

Date:

Required Attachment Certification Checklist

Qualification Requirements. I certify that my firm meets the following requirements:		Confirmed by DHS
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	My firm possesses at least three consecutive years of experience of the various service types listed in Item 1 of the RFP section entitled, "Qualification Requirements." That experience occurred within the past five years.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	My firm has read and is willing to comply with the terms, conditions and contract exhibits addressed in the RFP section entitled, "Contract Terms and Conditions".	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	(Corporations) My firm is in good standing and qualified to conduct business in California. [Check "N/A" if not a Corporation.]	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	My firm has a past record of sound business integrity and a history of being responsive to past contractual obligations. My firm authorizes the State to confirm this claim.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	My firm is financially stable and solvent and has adequate cash reserves to meet all financial obligations while awaiting reimbursement from the State.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	My firm has complied with the DVBE actual participation and/or good faith effort requirements as instructed in the DVBE Instructions / Forms (Attachment 8).	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	My firm has no conflict of interest and has submitted the required certification and documentation necessary to prove this claim.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	My firm will supply, before contract execution, proof of self-insurance or copies of insurance certificates showing proof of general liability and/or automobile liability insurance as stipulated in The RFP section entitled, "Qualification Requirements".	<input type="checkbox"/> Yes <input type="checkbox"/> No
Technical Proposal Format and Content.		
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	My firm complied with the Technical Proposal format requirements and my firm submitted one original Technical Proposal, five (5) copies and a CD-R copy of the Proposal. My proposal is assembled in the following order:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Proposal Cover Page (Attachment 1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Table of Contents	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Executive Summary section (3 pages or less)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Agency Capability section	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Work Plan section	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Management Plan section	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Project Personnel section	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Facilities and Resources section	<input type="checkbox"/> Yes <input type="checkbox"/> No

Required Attachment / Certification Checklist

Cost section with the following documentation:		Confirmed by DHS
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachments 10-1 to 10-7, Cost Matrix forms. Form 10-7 is signed. Corrections, if any, have been initialed. All cost figures have been double-checked for accuracy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 10-8, Cost Proposal form. Form is signed. Corrections, if any, have been initialed. All cost figures have been double-checked for accuracy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachments 11-1 to 11-6, Core Deliverable forms. Corrections, if any, have been initialed. All cost figures have been double-checked for accuracy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendix section with the following documentation:		
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	(Corporations) A copy of your firm's most current Certificate of Status issued by the Secretary of State's Office. Explain if the required document cannot be attached. [Check "N/A" if not a corporation.]	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	An organization chart.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Copies of financial statements for the past two years or most recent 24-month period (i.e., quarterly/annual Income Statements, Balance Sheets, Statement of Cash Follow).	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Resumes of the Proposer's professional staff (i.e. managers, supervisors, and technical experts) who will play a major administrative, policy or consulting role in carrying out the project work.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Resumes for each pre-identified subcontractor or independent consultant, if any, which will serve a major role in performing the services. [Check "N/A" if you will not use subcontractors or consultants or if you have not pre-identified any such entities.]	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	A sample presentation and example of writing style is attached to the proposal.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Letters of agreement, signed by each pre-identified subcontractor and independent consultant or applicable explanation. [Check "N/A" if you will not use subcontractors or consultants or if you have not pre-identified any such entities.]	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Proof that no prohibited conflicts of interest exist via Attachment 13 with applicable documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Form Section with the Following Attachments / Forms:		
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 2, Required Attachment / Certification Checklist	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 3, Proposer Information Sheet	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 4, Proposer References	<input type="checkbox"/> Yes <input type="checkbox"/> No

Required Attachment / Certification Checklist

Form Section with the Following Attachments / Forms:		Confirmed by DHS
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 5, RFP Clause Certification	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 6, CCC 201 – Certification	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Attachment 7, Payee Data Record. [Check “N/A” if you have had a prior contract with DHS.]	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Actual DVBE Participation (Attachment 8a) and DVBE certifications for each subcontractor or supplier listed. Complete this form according to the instructions in Attachment 8 if you attained partial or a full 3% DVBE participation. [Indicate “N/A” if you achieved zero participation and chose to complete the good faith effort form.]	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> N/A	Good Faith Effort (Attachment 8b) and applicable GFE documentation. Complete this form if you did not attain a full 3% DVBE participation. [Check “N/A” if you achieved a full 3% DVBE participation and submitted Attachment 8a or check “N/A” if the proposed cost for the entire contract term is <u>under \$10,000.</u>]	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Firm:		
Printed Name/Title:		
Signature		Date:

Proposer Information Sheet

Our inclusive cost proposal is attached. A signature affixed hereon and dated certifies compliance with all bid requirements. Our signature authorizes the State to verify the claims made on this certification.

Name of Firm:		CA Corp. No. (If applicable)		Federal ID Number
Name of Principal (If not an individual):	Title:		Telephone Number	Fax Number
Street Address / P.O. Box		City	State	Zip Code

Type of Business Organization / Ownership (Check all that apply)**Ownership**

- ☐ Sole Proprietor
☐ Partnership
☐ Joint venture
☐ Association

Corporation

- ☐ Nonprofit
☐ For Profit
☐ Private
☐ Public

Governmental

- ☐ City/County, California State Agency, Federal Agency, State (other than California)
☐ Other:

Other Type of Entity

- ☐ Public or Municipal Corporation, School or Water District, California State College, University of California, Joint Powers Agency
☐ Auxiliary College Foundation
☐ Other:

California Certified Small Business Status ☐ N/A ☐ Microbusiness ☐ Small business

☐ Certified By DGS Certification No: _____ Expiration Date: _____

If certified, attach a copy of certification letter.

If an application is pending, date submitted to DGS: _____

Small Business Type (If applicable) ☐ N/A ☐ Services ☐ Non-Manufacturer ☐ Manufacturer

☐ Contractor (Construction Type): _____ ☐ Contractor's License Type: _____

Veteran Status of Business Owner ☐ N/A

☐ Disabled Veteran Certified by DGS Certification No. _____ Expiration Date: _____

If certified, attach a copy of certification letter.

If an application is pending, date submitted to DGS: _____

Disadvantaged Business Enterprise Status: ☐ N/A ☐ Approved by the Cal Trans, Office of Civil Rights.

Certification number issued by Cal Trans: _____ Expiration Date: _____

Race/Ethnicity of Business Owner ☐ N/A ☐ Black ☐ Hispanic ☐ Non-Minority or Caucasian

☐ Asian Indian ☐ Pacific Asian ☐ Native American ☐ Other _____

Sex of Business Owner ☐ N/A (Not independently owned) ☐ Male ☐ Female

Indicate applicable licenses and/or certifications possessed:

☐ N/A

Contractor's State Licensing Board No.

PUC License Number
CAL-T-

Required Licenses/Certifications (If applicable)

Signature

Date Signed

Printed/Typed Name

Title

Public Records Information

The above information is required for statistical and/or bidding purposes. Completion of this form is mandatory. This information will be made public upon award of the contract and will be supplied to DHS' Contract Management Unit, Department of General Services and possibly other public agencies. To access your contract related records, contact the Contract Management Unit, 1800 3rd Street (Room 455), P.O. Box 942732, Sacramento, CA 94234-7432, telephone number (916) 322-6122.

Proposer References

List 3 clients served in the past 5-years for which you provided similar services. List the most recent first.

REFERENCE 1

Name of Firm

Street address	City	State	Zip Code
Contact Person	Telephone number ()		
Dates of service	Value or cost of service		
Brief description of service provided			

REFERENCE 2

Name of Firm

Street address	City	State	Zip Code
Contact Person	Telephone number ()		
Dates of service	Value or cost of service		
Brief description of service provided			

REFERENCE 3

Name of Firm

Street address	City	State	Zip Code
Contact Person	Telephone number ()		
Dates of service	Value or cost of service		
Brief description of service provided			

If three references cannot be provided, explain why:

RFP Clause Certification

I, the official named below, Certify Under Penalty of Perjury that I am duly authorized to legally bind the prospective Contractor to the certification clauses located in the RFP section entitled, “Bidding Certification Clauses”. This certification is made under the laws of the State of California.

Name of Bidding Firm (Printed)	Federal ID Number
By (<i>Authorized Signature</i>)	
Printed Name and Title of Person Signing	
Date Executed	Executed in the County of:

CCC 201 - CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

<i>Contractor/Bidder Firm Name (Printed)</i>		<i>Federal ID Number</i>
<i>By (Authorized Signature)</i>		
<i>Printed Name and Title of Person Signing</i>		
<i>Date Executed</i>	<i>Executed in the County of</i>	

CONTRACTOR CERTIFICATION CLAUSES

1. **STATEMENT OF COMPLIANCE:** Contractor has, unless exempted, complied with the nondiscrimination program requirements. (GC 12990 (a-f) and CCR, Title 2, Section 8103) (Not applicable to public entities.)
2. **DRUG-FREE WORKPLACE REQUIREMENTS:** Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:
 - a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.
 - b. Establish a Drug-Free Awareness Program to inform employees about:
 - 1) the dangers of drug abuse in the workplace;
 - 2) the person's or organization's policy of maintaining a drug-free workplace;
 - 3) any available counseling, rehabilitation and employee assistance programs; and,
 - 4) penalties that may be imposed upon employees for drug abuse violations.
 - c. Every employee who works on the proposed Agreement will:
 - 1) receive a copy of the company's drug-free workplace policy statement; and,
 - 2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: (1) the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (GC 8350 et seq.)
3. **NATIONAL LABOR RELATIONS BOARD CERTIFICATION:** Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court which orders Contractor to comply with an order of the National Labor Relations Board. (PCC 10296) (Not applicable to public entities.)
4. **UNION ORGANIZING** Contractor hereby certifies that no request for reimbursement, or payment under this agreement, will seek reimbursement for costs incurred to assist, promote or deter union organizing.

STATE OF CALIFORNIA **PAYEE DATA RECORD**
(Required in lieu of IRS W-9 when doing business with the State of California)
STD. 204 (REV. 2-99)

NOTE: Governmental entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee

1	DEPARTMENT/OFFICE STREET ADDRESS CITY, STATE, ZIP CODE TELEPHONE NUMBER	PURPOSE: Information contained in this form will be used by state agencies to prepare information Returns (Form 1099) and for withholding on payments to nonresident payees. Prompt return of this fully completed form will prevent delays when processing payments. <i>(See Privacy Statement on reverse)</i>				
2	PAYEE'S BUSINESS NAME SOLE PROPRIETOR—ENTER OWNER'S FULL NAME HERE (<i>Last, First, M.I.</i>) MAILING ADDRESS (<i>Number and Street or P. O. Box Number</i>) (<i>City, State and Zip Code</i>)					
3	CHECK ONE BOX ONLY <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> MEDICAL CORPORATION (<i>including dentistry, podiatry, psychotherapy, optometry, chiropractic, etc.</i>) <input type="checkbox"/> EXEMPT CORPORATION (Nonprofit) <input type="checkbox"/> ALL OTHER CORPORATIONS </div> <div style="width: 45%;"> <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST <input type="checkbox"/> INDIVIDUAL/SOLE PROPRIETOR </div> </div>	NOTE: State and local governmental entities, including school districts are not required to submit this form.				
4	SOCIAL SECURITY NUMBER REQUIRED FOR INDIVIDUAL/SOLE PROPRIETOR BY AUTHORITY OF THE REVENUE AND TAXATION CODE SECTION 18646 (See reverse) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> FEDERAL EMPLOYERS IDENTIFICATION NUMBER (FEIN) <div style="border-bottom: 1px solid black; width: 100%;"></div> IF PAYEE ENTITY TYPE IS A CORPORATION, PARTNERSHIP, ESTATE OR TRUST, ENTER FEIN. </div> <div style="width: 45%;"> SOCIAL SECURITY NUMBER <div style="border-bottom: 1px solid black; width: 100%;"></div> (IF PAYEE ENTITY TYPE IS INDIVIDUAL/SOLE PROPRIETOR, ENTER SSAN. </div> </div>		NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.			
5	CHECK APPROPRIATE BOX(ES) <input type="checkbox"/> California Resident – Qualified to do business in CA or a permanent place of business in CA <input type="checkbox"/> Nonresident (<i>See Reverse</i>) Payments to nonresidents for services may be subject to state withholding <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA	NOTE: a. An estate is a resident if decedent was a California resident at time of death. b. A trust is a resident if at least one trustee is a California resident. (See reverse)				
6	<p style="text-align: center;"><i>I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"> AUTHORIZED PAYEE REPRESENTATIVE'S NAME (<i>Type or Print</i>) </td> <td style="width: 40%;"> TITLE </td> </tr> <tr> <td> SIGNATURE </td> <td> <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;">DATE</div> <div style="width: 60%;">TELEPHONE NUMBER</div> </div> </td> </tr> </table>		AUTHORIZED PAYEE REPRESENTATIVE'S NAME (<i>Type or Print</i>)	TITLE	SIGNATURE	<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;">DATE</div> <div style="width: 60%;">TELEPHONE NUMBER</div> </div>
AUTHORIZED PAYEE REPRESENTATIVE'S NAME (<i>Type or Print</i>)	TITLE					
SIGNATURE	<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;">DATE</div> <div style="width: 60%;">TELEPHONE NUMBER</div> </div>					

STATE OF CALIFORNIA PAYEE DATA RECORD
(Required in lieu of IRS W-9 when doing business with the State of California)
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SECTION 1 must be completed by the requesting state agency before forwarding to the payee

204PRT.FRP

ARE YOU A RESIDENT OR A NONRESIDENT?

Each corporation, individual/sole proprietor, partnership, estate or trust doing business with the State of California must indicate their residency status along with their taxpayer identification number.

A **corporation** will be considered a “resident” if it has a permanent place of business in California. The corporation has a permanent place of business in California if it is organized and existing under the laws of this state or, if a foreign corporation has qualified to transact intrastate business. A corporation that has not qualified to transact intrastate business (e.g., a corporation engaged exclusively in interstate commerce) will be considered as having a permanent place of business in this state only if it maintains a permanent office in this state that is permanently staffed by its employees.

For **individuals/sole proprietors**, the term “resident” includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose which will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident.

For withholding purposes, a **partnership** is considered a resident partnership if it has a permanent place of business in California. An estate is considered a California estate if the decedent was a California resident at the time of death and a trust is considered a California trust if at least one trustee is a California resident.

More information on residency status can be obtained by calling the Franchise Tax Board at the numbers listed below:

From within the United States, call.....1-800-852-5711
From outside the United States, call.....1-916-845-6500
For hearing impaired with TDD, call....1-800-822-6268

ARE YOU SUBJECT TO NONRESIDENT WITHHOLDING?

Payments made to nonresident payees, including corporations, individuals, partnerships, estates and trusts, are subject to withholding. Nonresident payees performing services in California or receiving rent, lease or royalty payments from property (real or personal) located in California will have 7% of their total payments withheld for state income taxes. However, no withholding is required if total payments to the payee are \$1500 or less for the calendar year.

A nonresident payee may request that income taxes be withheld at a lower rate or waived by sending a completed form FTB 588 to the address below. A waiver will generally be granted when a payee has a history of filing California returns and making timely estimated payments. If the payee activity is carried on outside of California or partially outside of California, a waiver or reduced withholding rate may be granted. For more information, contact:

Franchise Tax Board
Nonresident Withholding Section
Attention: State Agency Withholding Coordinator
P.O. Box 651 Sacramento, CA 95812-0651
Telephone: (916) 845-4900
FAX: (916) 845-4831

If a reduced rate of withholding or waiver has been authorized by the Franchise Tax Board, attach a copy to this form.

PRIVACY STATEMENT

Section 7(b) of the Privacy Act of 1974 (Public Law 93-5791) requires that any federal, state, or local governmental agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

The State of California requires that all parties entering into business transactions that may lead to payment(s) from the State must provide their Taxpayer Identification Number (TIN) as required by the State Revenue and Taxation Code, Section 18646 to facilitate tax compliance enforcement activities and to facilitate the preparation of Form 1099 and other information returns as required by the Internal Revenue Code, Section 6109(a). The TIN for individual and sole proprietorships is the Social Security Number (SSN).

It is mandatory to furnish the information requested. Federal law requires that payments for which the requested information is not provided be subject to a 31% withholding and state law imposes noncompliance penalties of up to \$20,000.

You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the state agency(ies) with which you transact that business.

Please call the Department of Finance, Fiscal Systems and Consulting Unit at (916) 324-0385 if you have any questions regarding this Privacy Statement. Questions related to residency or withholding should be referred to the telephone numbers listed above. All other questions should be referred to the requesting agency listed in Section 1.

Voluntary Letter of Intent Intent

Purpose	This is a non-binding Letter of Intent whose purpose is to assist DHS in determining the staffing needs for the proposal evaluation process and to improve future procurements.
Information requested	DHS is interested in knowing if your firm intends to submit a proposal or your reasons for not submitting a proposal. Completion of this form is voluntary.
Action to take	Indicate your intention to submit a proposal by checking items 1 or 2 below. Follow the instructions below your selection.

1. ☐ My firm intends to submit a proposal.

- A. Check box number 1 if the above statement reflects your intention.
- B. Complete the bottom portion of this form and return it to DHS as instructed in the RFP section entitled, "Letter of Intent".
-

2. ☐ My firm does not intend to submit a proposal for this project.

- A. Check box number 2 if the statement in item 2 reflects your intention.
- B. Indicate your reason(s) for not submitting a proposal by checking any of the following statements that may apply.

- ☐ My firm lacks sufficient staff expertise or personnel resources to meet the requirements.
- ☐ My firm lacks sufficient experience (i.e., not enough or wrong type).
- ☐ My firm believes the qualification requirements are too restrictive.
- ☐ Not enough time was allowed for proposal preparation.
- ☐ Too much paperwork is required to prepare a proposal response.
- ☐ Other commitments and projects have a greater priority.
- ☐ My firm did not learn about the contract opportunity soon enough.
- ☐ My firm does not provide the full range of services that DHS is seeking.
- ☐ My firm is only interested in becoming a subcontractor, consultant or supplier.
- ☐ My firm cannot meet the DVBE requirements - we do not wish to subcontract any work out.
- ☐ Too much effort and/or paper work is required to meet California DVBE requirements.
- ☐ Insufficient time was allowed for DVBE compliance.
- ☐ Other reason: _____
-

- C. Complete the bottom portion of this form and return it to DHS as instructed in the RFP section entitled, "Letter of Intent".
- D. By indicating that you do not intend to submit a proposal, DHS may elect not to send your firm RFP clarification notices, RFP addenda, proposer questions and answers, or other procurement notices.
-

Name of Firm: _____

Printed Name/Title: _____

Signature: _____

Date: _____

Cost Matrix

Auditing and Reporting of External Accountability Set Performance Measures

Preliminary Report of the External Accountability Set Compliance Audits

Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Plan Specific Reports at the County Level of Analysis	\$ To Attachment 11-1. 1	\$ To Attachment 11-1. 2	\$ To Attachment 11-1. 3	\$ To Attachment 11-1. 4	\$ To Attachment 11-1. 5
Plan Specific Reports at the County and Subcontractor Plan Level of Analysis	\$	\$	\$	\$	\$

Final Report of the External Accountability Set Compliance Audit Results

Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Plan Specific Reports at the County Level of Analysis	\$ To Attachment 11-1. 1	\$ To Attachment 11-1. 2	\$ To Attachment 11-1. 3	\$ To Attachment 11-1. 4	\$ To Attachment 11-1. 5
Plan Specific Reports at the County and Subcontractor Plan Level of Analysis	\$	\$	\$	\$	\$

Cost Matrix

Audit and Reporting of External Accountability Set Performance Measures

Aggregate Reports of the External Accountability Set Compliance Audit Results					
Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Aggregate HEDIS Reports	\$ To Attachment 11-1. 1	\$ To Attachment 11-1. 2	\$ To Attachment 11-1. 3	\$ To Attachment 11-1. 4	\$ To Attachment 11-1. 5
Aggregate Department- Developed Performance Measures Reports	\$ To Attachment 11-1. 1	\$ To Attachment 11-1. 2	\$ To Attachment 11-1. 3	\$ To Attachment 11-1. 4	\$ To Attachment 11-1. 5

Cost Matrix

Reports Defining Superior Performance

Reports Defining Superior Performance					
Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Interim Report of Defining Superior Performance	\$ To Attachment 11-1. 1	Not Required	Not Required	Not Required	Not Required
Final Report of Defining Superior Performance	\$ To Attachment 11-1. 1	Not Required	Not Required	Not Required	Not Required

Cost Matrix

Quality Improvement Projects (QIPs) Reports

Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Report of QIP Evaluation Criteria	\$ To Attachment 11-1. 1	Not Required	Not Required	Not Required	Not Required
Quarterly Status Report of QIP	\$ To Attachment 11-1. 1	\$ To Attachment 11-1. 2	\$ To Attachment 11-1. 3	\$ To Attachment 11-1. 4	\$ To Attachment 11-1. 5
Report of Baseline Measurement for the Statewide Collaborative QIP	\$ To Attachment 11-1. 1	Not Required	\$ To Attachment 11-1. 3	Not Required	\$ To Attachment 11-1. 5
Status Report of the Statewide Collaborative QIP	Not Required	\$ To Attachment 11-1. 2	Not Required	\$ To Attachment 11-1. 4	Not Required
Report on the Remeasurement of Statewide Collaborative QIP	Not Required	\$ To Attachment 11-1. 2	Not Required	\$ To Attachment 11-1. 4	Not Required

Cost Matrix
Evaluation Reports

Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Plan-Specific Evaluation Reports	\$ To Attachment 11-1. 1	\$ To Attachment 11-1. 2	\$ To Attachment 11-1. 3	\$ To Attachment 11-1. 4	\$ To Attachment 11-1. 5
Medi-Cal Managed Care Evaluation Report	\$ To Attachment 11-1. 1	\$ To Attachment 11-1. 2	\$ To Attachment 11-1. 3	\$ To Attachment 11-1. 4	\$ To Attachment 11-1. 5

Cost Matrix

Reports of Consumer Satisfaction Survey

Plan-Specific Reports of Consumer Satisfaction Survey Results					
Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Plan Specific Reports Using CAHPS 2.0 H English and Spanish	\$	Not Required	\$	Not Required	\$
Plan Specific Reports Using CAHPS Revised 2.0 H English & Spanish	\$	Not Required	\$	Not Required	\$
Plan Specific Reports Using CAHPS 2.0 H Five (5) Languages	Not Required	Not Required	\$	Not Required	\$
Plan Specific Reports Using CAHPS Revised 2.0 H Five (5) Languages	Not Required	Not Required	\$	Not Required	\$

Cost Matrix

Reports of Consumer Satisfaction Survey

Summary Report of Consumer Satisfaction Survey Results

Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Summary Report Using CAHPS 2.0 H English and Spanish	\$	Not Required	\$	Not Required	\$
Summary Report Using CAHPS Revised 2.0 H English & Spanish	\$	Not Required	\$	Not Required	\$
Summary Report Using CAHPS 2.0 H Five (5) Languages	Not Required	Not Required	\$	Not Required	\$
Summary Report Using CAHPS Revised 2.0 H Five (5) Languages	Not Required	Not Required	\$	Not Required	\$

Cost Matrix**Annual Quality Improvement Conference**

Annual Quality Improvement Conference					
Deliverable	Contract Year 1 Ending 09/30/2003	Contract Year 2 Ending 9/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 09/30/2004	Extension Year 2 Ending 09/30/2005
Annual Quality Improvement Conference	Not Required	\$ To Attachment 11-1. 2	\$ To Attachment 11-1. 3	\$ To Attachment 11-1. 4	\$ To Attachment 11-1. 5

Cost Matrix
Hourly Rate for Consultative Services

YEAR	Contract Year 1 Ending 9/30/2003	Contract Year 2 Ending 09/30/2004	Contract Year 3 Ending 09/30/2005	Extension Year 1 Ending 09/30/2004	Extension Year 2 Ending 09/30/2005
Specialist					
Physician Consultant	\$	\$	\$	\$	\$
Epidemiologist	\$	\$	\$	\$	\$
Nurse Consultant	\$	\$	\$	\$	\$
Information Technology Analyst	\$	\$	\$	\$	\$
Business Analyst	\$	\$	\$	\$	\$
Biostatistician	\$	\$	\$	\$	\$
Actuary	\$	\$	\$	\$	\$

10-8

Cost Proposal Form

The undersigned proposer hereby agrees to furnish all labor, transportation, equipment, materials and support services necessary to provide the Deliverables as described in the Scope of Work and Request for Proposal 01-16170 for the sums indicated in Attachments 10-1, 10-2, 10-3, 10-4, 10-5, 10-6 and 10-7 .

Is the proposer claiming preference as a certified California small business or microbusiness?

☐
Yes

☐
No

The undersigned proposer hereby affirms that the statements/claims made in the Technical/Cost Proposal are true and accurate to the best of the proposer's knowledge. By signing this Cost Proposal, the proposer hereby claims his/her willingness to certify to and comply with all requirements contained in this RFP and all RFP attachments/forms. The undersigned recognizes that its Technical and Cost Proposal shall become public records upon posting of intent to award will be open to public inspection.

Name of Firm:

Street address

City/State

Zip Code:

Telephone number:

()

Facsimile number:

Printed name:

Title:

Signature:

Date:

Core Deliverables Year 1

Report / Activity	Bid Amount	Times	Number of Units	Total
Preliminary Plan Specific EAS Reports (Analysis at the County Level)	\$	X	22	\$
Final Plan Specific EAS Reports (Analysis at the County Level)	\$	X	22	\$
Aggregate HEDIS Report	\$	X	1	\$
Aggregate Department-Developed Performance Measures Report	\$	X	1	\$
Interim Report Defining Superior Performance	\$	X	1	\$
Final Reports Defining Superior Performance	\$	X	1	\$
Report of QIP Evaluation Criteria	\$	X	1	\$
Quarterly Status Report of QIPs	\$	X	4	\$
Report of Baseline Measurement for the Statewide Collaborative QIP	\$	X	1	\$
Plan-Specific Evaluation Reports	\$	X	22	\$
Medi-Cal Managed Care Evaluation Report	\$	X	1	\$

Subtotal Year 1

\$

Copy the Subtotal Year 1 to Attachment 11-1. 6

Core Deliverables Year 2				
Report / Activity	Bid Amount	Times	Number of Units	Total
Preliminary Plan Specific EAS Reports (Analysis at the County Level)	\$	X	22	\$
Final Plan Specific EAS Reports (Analysis at the County Level)	\$	X	22	\$
Aggregate HEDIS Report	\$	X	1	\$
Aggregate Department-Developed Performance Measures Report	\$	X	1	\$
Quarterly Status Report of QIPs	\$	X	4	\$
Status Report of Statewide Collaborative QIP	\$	X	1	\$
Remeasurement Statewide Collaborative QIP Report	\$	X	1	\$
Plan-Specific Evaluation Reports	\$	X	22	\$
Medi-Cal Managed Care Evaluation Report	\$	X	1	\$
Annual Quality Improvement Conference	\$	X	1	\$
Subtotal Year 2		\$		

Copy the Subtotal Year 2 to Attachment 11-1. 6

Core Deliverables Year 3

Report / Activity	Bid Amount	Times	Number of Units	Total
Preliminary Plan Specific EAS Reports (Analysis at the County Level)	\$	X	22	\$
Final Plan Specific with Analysis at the County Level	\$	X	22	\$
Aggregate HEDIS Report	\$	X	1	\$
Aggregate Department-Developed Performance Measures Report	\$	X	1	\$
Quarterly Status Report of QIPs	\$	X	4	\$
Report of Baseline Measurement for the second Statewide Collaborative QIP	\$	X	1	\$
Plan-Specific Evaluation Reports	\$	X	22	\$
Medi-Cal Managed Care Evaluation Report	\$	X	1	\$
Annual Quality Improvement Conference	\$	X	1	\$

Subtotal Year 3

\$

Copy the Subtotal Year 2 to Attachment 11-1. 6

Core Deliverables First Extension Year

Report / Activity	Bid Amount	Times	Number of Units	Total
Preliminary Plan Specific EAS Reports (Analysis at the County Level)	\$	X	22	\$
Final Plan Specific with Analysis at the County Level	\$	X	22	\$
Aggregate HEDIS Report	\$	X	1	\$
Aggregate Department-Developed Performance Measures Report	\$	X	1	\$
Quarterly Status Report of QIPs	\$	X	4	\$
Status Report of the second Statewide Collaborative QIP	\$	X	1	\$
Remeasurement of the second Statewide Collaborative QIP Report	\$	X	1	\$
Plan-Specific Evaluation Reports	\$	X	22	\$
Medi-Cal Managed Care Evaluation Report	\$	X	1	\$
Annual Quality Improvement Conference	\$	X	1	\$

Subtotal First Extension Year

\$

Copy the Subtotal First Extension Year to Attachment 11-1. 6

Core Deliverables Second Extension Year
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Report / Activity	Bid Amount	Times	Number of Units	Total
Preliminary Plan Specific EAS Reports (Analysis at the County Level)	\$	X	22	\$
Final Plan Specific with Analysis at the County Level	\$	X	22	\$
Aggregate HEDIS Report	\$	X	1	\$
Aggregate Department-Developed Performance Measures Report	\$	X	1	\$
Quarterly Status Report of QIPs	\$	X	4	\$
Report of Baseline Measurement for the second Statewide Collaborative QIP	\$	X	1	\$
Plan-Specific Evaluation Reports	\$	X	22	\$
Medi-Cal Managed Care Evaluation Report	\$	X	1	\$
Annual Quality Improvement Conference	\$	X	1	\$
Subtotal Second Extension Year			\$	

Copy the Subtotal Second Extension Year to Attachment 11-1. 6

Core Deliverables Subtotals & Grand Total
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Subtotal Year 1	\$
Subtotal Year 2	\$
Subtotal Year 3	\$
Subtotal First Extension Year	\$
Subtotal Second Extension Year	\$
Grand Total Years 1, 2 & 3, 1st & 2nd Year Extension	\$

**Schedule for
Enhanced Deliverables**

Cost Matrix Bid Element to be Evaluated	Contact Year 1	Contract Year 2	Contract Year 3	First Extension Year	Second Extension Year	Value Factor	Maximum Raw Points Achievable
Preliminary Plan Specific EAS Reports (Analysis at the County & Subcontractor Level)	Yes	Yes	Yes	Yes	Yes	1.5	7.5
Final Plan Specific EAS Reports (Analysis County & Subcontractor Level)	Yes	Yes	Yes	Yes	Yes	1.0	5.0
Plan Specific Reports of CAHPS 2.0 H in English & Spanish (Analysis at Contract Level)	YES	No	Yes	No	Yes	1.5	4.5
Plan Specific Reports of CAHPS Revised 2.0 H in English & Spanish (Analysis at Contract Level)	YES	No	Yes	No	Yes	1.0	3.0
Plan Specific Reports of CAHPS 2.0 H in Five (5 Languages) (Analysis at Contract Level)	No	No	Yes	No	Yes	1.0	2.0
Plan Specific Reports of CAHPS Revised 2.0 H in Five (5 Languages) (Analysis at Contract Level)	No	No	Yes	No	Yes	1.0	2.0
Summary Report of CAHPS 2.0 H in English & Spanish (Analysis at Contract Level)	Yes	No	Yes	No	Yes	1.5	4.5
Summary Report of CAHPS Revised 2.0 H in English & Spanish (Analysis at Contract Level)	Yes	No	Yes	No	Yes	1.0	3.0
Summary Report of CAHPS 2.0 H in Five (5 Languages) (Analysis at Contract Level)	No	No	Yes	No	Yes	1.0	2.0
Summary Report of CAHPS Revised 2.0 H in Five (5 Languages) (Analysis at Contract Level)	No	No	Yes	No	Yes	1.0	2.0
Subtotal of Points Available for Enhanced Deliverables							35.5

Cost Matrix Bid Element to be Evaluated	Contact Year 1	Contract Year 2	Contract Year 3	First Extension Year	Second Extension Year	Factor Value	Maximum Raw Points Achievable
Hourly Rate for Consultative Services of a Physician Consultant	Yes	Yes	Yes	Yes	Yes	1.0	5.0
Hourly Rate for Consultative Services of an Epidemiologist	Yes	Yes	Yes	Yes	Yes	1.5	7.5
Hourly Rate for Consultative Services of a Nurse Consultant	Yes	Yes	Yes	Yes	Yes	1.0	5.0
Hourly Rate for Consultative Services of an Information Technology Analyst	Yes	Yes	Yes	Yes	Yes	1.0	5.0
Hourly Rate for Consultative Services of a Business Analyst	Yes	Yes	Yes	Yes	Yes	1.0	5.0
Hourly Rate for Consultative Services of a Biostatistician	Yes	Yes	Yes	Yes	Yes	1.5	7.5
Hourly Rate for Consultative Services of an Actuary	Yes	Yes	Yes	Yes	Yes	1.5	7.5
Subtotal of Points Available for Enhanced Deliverables							<u>42.5</u>
Grand Total of Raw Points Available for Enhanced Deliverables							<u>78</u>

Conflict of Interest Compliance Certificate

- A. The State and DHS intends to avoid conflicts of interest or the appearance of conflicts of interest on the part of the Contractor, subcontractors, employees, officers or directors of the Contractor or subcontractors. Thus, the State and DHS reserves the right to determine, at their sole discretion, whether any information received from any source indicates the existence of a conflict of interest.
- B. Any of the following instances would be considered a potential “conflict of interest”, including, but not limited to any instance in the past, present or future:
1. Where the Contractor contracts with any Managed Care Plan, a plan partner of any Managed Care Plan or a provider subcontractor to any Managed Care Plan which is intended to be audited or reviewed by Contractor.
 2. Where the Contractor has an Interest in a Managed Care Plan or its affiliates.
 3. Where the Managed Care Plan or its affiliates have an Interest in the Contractor.
 4. Where a Contractor officer, director or employee, and their spouse or dependent child, is employed by a Managed Care Plan or its affiliates or has an Interest in a Managed Care Plan or its affiliates.
 5. Where pursuant to the Political Reform Act (Government Code Section 87100-87500), a DHS official has an economic interest in the Contractor and the official makes, participates in the making of, or uses his or her official position to influence the making of a decision involving Contractor, where it is reasonably foreseeable that the decision could materially affect the official's economic interest.
 6. Where pursuant to Government Code Section 1090 et seq., a DHS official participates in the making of a contract with Contractor and the official is financially interested in the contract.
- C. The Contractor conducting the HEDIS performance audit or CAHPS surveys must conform to any and all conflict of interest requirements of the National Committee of Quality Assurance (NCQA) with regards to the execution of the HEDIS audits and CAHPS surveys.
- D. If the State is aware or becomes aware of a known or suspected conflict of interest, the Contractor will be given an opportunity to submit additional information to resolve the conflict. A proposer or Contractor with a suspected conflict of interest will have five (5) working days from the date of notification of the conflict by the State to provide complete information regarding the suspected conflict. If a conflict of interest is determined to exist by the State and the conflict cannot be resolved or mitigated to the satisfaction of State, before or after the award of the contract, the conflict will be grounds for rejection of the proposal or termination for default of the contract.
- E. The term “interest” for purposes of conflict of Interest shall include any ownership of a partnership, S Corporation, Limited Liability Corporation, or interest or ownership of stock in a closely held corporation which holds an ownership position in a managed care plan. An “Interest” shall also be evidenced by any loan; corporate, personal, secured or unsecured, between a Managed Care Plan or its affiliates and a party or related party to this contract.
- The term "Contractor" for purposes of conflict of interest includes the Proposer/Contractor and Subcontractors, including the employees, officers and directors of these entities.

The term "Subcontractor" for purposes of conflict of interest is limited to those individuals or entities who contract with the Contractor/proposer to perform any part of the Scope of Work in RFP Section H.

- F. Any form of ownership or interest held through the ownership of a publicly trade mutual fund shall not be deemed a conflict of interest solely on the basis mutual fund ownership. Ownership of publicly traded stock by Contractor, in a corporation which owns or controls a Managed Care Plan or its affiliates should be reported if the stock ownership is at least five percent of the outstanding stock in the corporation.
- G. The proposer shall include in the Technical Proposal/Required Attachments this Certificate containing the original signature of an official or employee of the proposer who is authorized to bind the proposer.
- H. This Certificate will be incorporated into the contract, if any, awarded from this RFP. It is understood that this requirement shall be in effect for the entire term of the contract, including extensions, if any. The Contractor shall obtain a completed Certificate from any proposed subcontractor and submit it to State DHS prior to approval of the subcontractor by State DHS.
- I. **The Contractor and each subcontractor shall notify State DHS, Medi-Cal Managed Care Division, at 714 P Street, PO Box 942732, Sacramento, CA 94234-7320 within ten (10) business days of any change to the information provided on this Certificate.**
- J. If the proposer has a suspected or potential conflict of interest, the proposer shall provide a description of the relationship, a plan for ensuring that such a relationship will not adversely affect the State, and procedures to guard against the existence of an actual Conflict of Interest

The undersigned hereby affirms that: (check one)

☐

The statements above have been read and that no conflict of interest exists that would jeopardize the ability of the firm to perform.

☐

A suspected or potential conflict of interest does exist, and additional information (as described in J. above) is attached along with a plan to address the possible conflict of interest.

Signed: _____ Title: _____ Date: _____

Type or Print Name of Authorized Representative:
